State of Arkansas Cafeteria Plan (ARCAP)
CHANGE IN STATUS FORM

Social Security #	Dept./Agency			
Last Name (Please Print)	First Name			MI
Home Address Street		City	State	ZIP
Work Phone ( )	Home Phone ( )	E-mail		

Please indicate the type of Change in Status incurred:

_____ Marriage
_____ Divorce
_____ Death (employee, spouse, or dependent)
_____ Birth of child
_____ Adoption of child
_____ Beginning or end of employment of spouse
_____ Ineligibility of dependent (due to age, marriage or loss of full-time student status)
_____ From full-time to part-time employment or vice versa (employee or spouse)
_____ Unpaid leave of absence (employee or spouse)
_____ Significant change in health coverage due to spouse's employment

This is to certify that on _____ (date of event), I incurred the Change In Status checked above, and therefore wish to change my plan benefits as indicated below. I understand that the change requested must be consistent with the change status event and I have attached legal document of such change.*

Signature _____ Date _____

**Examples of documentation include marriage, birth, or death certificate; divorce decrees; notices of legal separation; proof of change in spouse's employment; or adoption papers.*

CHANGE REQUESTED

STATE EMPLOYEE INSURANCE PREMIUM CONVERSION

I wish to have the following premiums taken from my paycheck *BEFORE* taxes are applied.

☐ State Employee/Dependent Health Insurance and/or State Employee Life Insurance (Dependent Term Life Insurance is not included in Premium Conversion)

I wish to have the following premiums taken from my paycheck *AFTER* taxes are applied.

☐ State Employee/Dependent Health Insurance and/or State Employee Life Insurance (Dependent Term Life Insurance is not included in Premium Conversion)

If you are changing health and/or life insurance coverage, please indicate change below.

State Employee Health Insurance (check one)

☐ Change to Employee Only coverage
☐ Change to Employee & Spouse Coverage
☐ Change to Employee & Children coverage
☐ Change to Employee/Spouse/Children coverage
☐ Change to NO COVERAGE

State Employee Life Insurance

☐ Increase in Optional Life Insurance

Employee Cancer Insurance

☐ Change coverage to _____

Employee Disability Insurance

☐ Change coverage to _____

DEPENDENT CARE Spending Account

☐ **Terminate Account**

☐ **Start Account:** I wish to contribute $ _____ total during the remainder of this plan year, to be taken in equal installments from my remaining regular paychecks.

Change Existing Account:

☐ I wish to change from $ _____ _____ annual reduction to $ _____annual reduction amount to be taken in equal installments from my remaining regular paychecks.

MEDICAL EXPENSE Spending Account

☐ **Terminate Account**

☐ **Start Account:** I wish to contribute $ _____ total during the remainder of this plan year, to be taken in equal installments from my remaining regular paychecks.

Change Existing Account:

☐ I wish to change from $ _____ annual reduction to $_____annual reduction amount to be taken in equal installments from my remaining regular paychecks.

EZ REIMBURSE® MasterCard® Card

Are you currently using the EZ REIMBURSE® MasterCard® Card with your Medical Expense FSA or Limited Medical Expense FSA? yes ☐ no ☐

Cancer and/or Disability Premium Conversion (check one)

☐ I wish to have Cancer and/or Disability Premiums taken from my salary before taxes are applied.

☐ I wish to have Cancer and/or Disability Premiums taken from my salary after taxes are applied.

Please indicate any change in coverage: _____

Mail completed form to:
Fringe Benefits Management Company
Metropolitan National Bank Tower
425 West Capitol, Suite 1518
Little Rock, AR 72201
Fax: (501)399-9333
Customer Service 1-800-342-8017

To be completed by **Fringe Benefits Management Company:**

Date received: _____ **Date confirmation sent:** _____
Date copy sent to state agency: _____
Coverage effective date: _____
Number of remaining paychecks: _____
New Amount: _____
Authorized by: _____

ADMINISTERED FOR THE STATE OF ARKANSAS BY FRINGE BENEFITS MANAGEMENT COMPANY